

**MAIL TO:**  
**Macori Administration**  
**P. O. Box 2508**  
**Spring, TX 77383-2508**  
**Outside Houston: 800-285-8133**  
**Houston Area: 281-651-8787**

**NOTIFICATION OF INJURY**

Any person who knowingly, and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

**FOR OFFICE USE ONLY**

Policy Number
Reference Number
Claim Number

**CLAIM INSTRUCTIONS:**

In case of accident, notify the school or group coordinator immediately.

1. Treatment must commence within 90 days from the date of the injury.
2. Send this claim form to us within 90 days from the date of the injury. DO NOT leave this form with the school, organization, coach, hospital, physician, etc.
3. Do not leave any blank spaces or write "N/A" in a space. If either parent is uninvolved, deceased, unemployed, self-employed or disabled, please state so. If you do not have insurance, please state "no insurance". If you are employed, please provide us with a statement from your employer that the claimant has no insurance. (Our office will submit an insurance questionnaire to your employer to be used as verification of no dependent coverage).
4. If claimant is insured under Medicaid, please indicate this.
5. Please attach itemized bills to the claim form, or mail them as soon as possible. An itemized bill includes treatment rendered, the dates of the treatment, physician's or hospital name, address and tax I.D. number, and diagnosis code. Balance Due bills are **not** acceptable.
6. If you have other insurance, your insurance company will send you an Explanation of Benefits (EOB) which shows what they paid or denied. We need a copy of the EOB for each itemized bill submitted to us.
7. Or, your provider(s) may forward the itemized bills to us along with the corresponding EOBs.
8. Our address is **Macori Administration, P. O. Box 2508, Spring, TX 77383**. Customer Service can be reached at **800-285-8133**. We are happy to assist you.
9. Benefits are paid to the providers of service unless we receive paid receipts.

**PART I – TO BE COMPLETED BY COACH, MANAGER OR PROPERLY DELEGATED AUTHORITY**

1. Name of School/Organization		2. Name of Team				
3. Name of Injured Individual		Last	First	Middle Initial	4. Social Security No.	5. Birthdate
6. Nature of Injury (Please describe fully indicating what part of body was injured – e.g. broken arm, sprained ankle, etc.)						
7. Describe how accident occurred. (Give all possible details.) <b>MUST BE A BODILY INJURY DUE TO ACCIDENT.</b>						
8. Did Accident Occur:		YES	NO	9. a) Date of Accident		10. Name of Activity/Sport
a) While claimant was supervised		<input type="checkbox"/>	<input type="checkbox"/>	b) Time		10A. (Check One)
b) During sponsored activity		<input type="checkbox"/>	<input type="checkbox"/>	c) Place		<input type="checkbox"/> Coach <input type="checkbox"/> Manager <input type="checkbox"/> Player/Member
c) During programmed hours		<input type="checkbox"/>	<input type="checkbox"/>	11. Name and Title of Supervisor		
d) On activity premises		<input type="checkbox"/>	<input type="checkbox"/>			
e) While traveling directly and uninterruptedly to or from a regularly scheduled activity in a supervised group		<input type="checkbox"/>	<input type="checkbox"/>			
12. Signature of Coach, Manager or Delegated Authority			13. Title		14. Date	

**NO CLAIM WILL BE PROCESSED UNLESS ALL INSTRUCTIONS ARE FOLLOWED AND FORM IS COMPLETED IN FULL**

**PART II – TO BE COMPLETED BY CLAIMANT – OR BY PARENT IF CLAIMANT IS A MINOR**

1. Name of Father or Guardian or Claimant (if adult)		2. Social Security No.	
3. Name of Mother or Guardian or Spouse (if adult)		4. Social Security No.	
5. Address of Parents or Guardian/or Claimant		5A. Telephone Number	
6A. Father or Guardian's or Claimant's Insurance Company(ies)		6B. Mother or Guardian's or Spouse's Insurance Company(ies)	
		Check One: <input type="checkbox"/> Individual <input type="checkbox"/> Group	
7A. Name, Address and Phone Number of Father or Guardian's or Claimant's Employer		7B. Name, Address and Phone Number of Mother or Guardian's or Spouse's Employer	
8. List other insurance policies under which claimant is insured Company		Policy No.	
		<input type="checkbox"/> Individual <input type="checkbox"/> Group	
1. _____		1A. _____	
		<input type="checkbox"/> Individual <input type="checkbox"/> Group	
2. _____		2A. _____	

**Affidavit:** I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws.

Signature of Parent or Guardian or Claimant \_\_\_\_\_ Date \_\_\_\_\_

**Authorization:** I hereby authorize any physician or hospital who has treated or attended the above claimant to furnish the insurance company or its representative any information requested. A photocopy of this authorization is to be considered valid.

Signature of Claimant (Parent or Guardian if Insured is a minor) \_\_\_\_\_ Date \_\_\_\_\_